Br J Vener Dis 1980;**56**:414-5

Correspondence

TO THE EDITOR, *British Journal of Venereal Diseases*

Conjunctivitis due to *Haemophilus ducreyi* infection

Sir,

Haemophilus ducreyi is an extremely rare cause of ocular infections.[1] This organism, which was described by Ducrey in 1889, is the aetiological agent of soft chancre or chancroid—a venereal disease. The natural reservoir of this small pleomorphic Gram-negative bacillus is the genitourinary tract of man. In civilian populations this bacterium may be responsible for up to 10% of reported cases of chancroid.[2]

A 25-year-old male medical student complained of acute conjunctivitis within four days of performing vaginal examinations on five female patients. His chief complaint was a pulsating ache and erythema of the conjunctiva of the left eye. There was also puffiness and tenderness of the upper lid of this eye and pain on attempted use of the extraocular muscles of the eye. A profuse yellow mucoid exudate was present in the medial punctum of the eye.

On closer examination it was noted that the scleral blood vessels were dilated with haemorrhage from some of these vessels. An enlarged non-tender left preauricular lymph node and a slightly enlarged non-tender submaxillary gland were detected by palpation. A presumptive diagnosis of epidemic keratoconjunctivitis, probably due to adenovirus, was made based on the clinical picture presented.

Approximately one hour after examination by an ophthalmologist and before treatment with an ophthalmic solution (naphazoline HCl in a dosage of 2-3 drops) into the infected eye in conjunction with cold compresses to reduce swelling a portion of the exudate was collected for culture using a cotton swab. A sheep-blood agar plate and a chocolate agar plate were inoculated and both incubated in a candle jar for 24 hours at 37°C. After this period a few identical tiny greyish translucent colonies were observed on both media; however, more colonies appeared on the chocolate agar than on the blood agar plate. A Gram stain of a few colonies from both media showed pleomorphic Gram-negative bacilli, morphologically consistent with the genus *Haemophilus*.

Three colonies from each medium were inoculated on to separate trypticase soy agar (TSA) plates; a V factor (nicotinamide adenine nucleotide) strip and an X factor (hemin) strip (Baltimore Biological Laboratory, Cockeysville, Maryland, USA) were placed on both plates. The plates were incubated under CO_2 tension in a candle jar at 37°C and examined after 24 hours.

Three colonies were also transferred to a test tube containing 10 ml of nitrate broth (Difco Laboratories, Detroit, Michigan, USA) and incubated for 24 hours at 37°C. The TSA plates showed tiny refractile colonies growing around the X factor strip; no growth occurred around the V factor strip. No change was observed in the nitrate broth indicating that the organism did not reduce nitrate to nitrite. The organism was identified as *Haemophilus ducreyi*.

After 11 days' treatment with the ophthalmic solution and cold compresses the patient became asymptomatic and has not experienced any recrudescence.

Yours faithfully,

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R W Henderson
R Smith

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TO THE EDITOR, *British Journal of Venereal Diseases*

Trichomonal urethritis in men

Sir,

I would like to offer a comment on your recent article[1] on the investigation of trichomonal urethritis in men. The technique was shown to be sensitive and capable of demonstrating small numbers of trichomonads in a urine specimen. However, when 18 of 21 male contacts of women known to have trichomonal vaginitis produced negative culture results the only conclusions offered were "that most male contacts shed relatively few trichomonads and that the infective dose for women must be correspondingly small."

May I suggest as an alternative, and more likely, conclusion that trichomonads were not found in these 18 men because they were not present in the first place.

This report would appear to confirm my suggestion[2] that trichomonal vaginitis is not (necessarily) a sexually transmitted disease.

Yours faithfully,

N Rosedale

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TO THE EDITOR, *British Journal of Venereal Diseases*

Treatment of lymphogranuloma venereum with rifampicin

Sir,

With reference to the letter on the "Treatment of lymphogranuloma venereum with rifampicin" by Menke and co-workers,[1] I

would like to make some comments on the reasons listed at the end of the letter, on which the authors base their conclusions not to recommend rifampicin for the treatment of lymphogranuloma venereum (LGV) despite the very encouraging results obtained.

The first reason seems to be concerned mainly with safety and is expressed in such a way as to imply indirectly that rifampicin is not safe. This is contradicted by extensive clinical evidence, including the lack of side effects reported by the authors themselves.

It should be pointed out in this context that the administration of rifampicin for relatively long periods in patients with a severe disease, such as tuberculosis, in combination with drugs such as streptomycin and isoniazid and more recently pyrazinamide is associated with an extremely low incidence of side effects. This evidence is based on data collected all over the world on hundreds of thousands of patients. A very exhaustive review of this argument has recently been made by Girling[2] of the British Medical Research Council. (I wonder what the data on the safety of tetracycline would be, had it been given—as was the case for rifampicin in the early phase of use—for periods up to 24 months on a continuous daily basis in the treatment of tuberculosis.)

The second reason refers to an alleged risk of increased resistance of *Mycobacterium tuberculosis* to rifampicin as a result of the use of this antibiotic in non-tuberculous infections. On this particular point, data from various countries where rifampicin is used for both tuberculous and non-tuberculous infections show that the sensitivity of *M tuberculosis* to rifampicin is practically 100% and very constant.[3] In some of these countries, the amount of antibiotic used in non-tuberculous infections (which is a good estimate of the selective pressure exerted on the sensitive bacterial population) is much higher than that used in tuberculosis.

As far as the third reason is concerned, one would expect that a definite clinical recommendation should be based on clinical data and not extrapolated from in-vitro data (which are valid as long as clinically confirmed).

In conclusion I think that the effective therapeutic value of rifampicin in LGV should be more appropriately established through controlled clinical trials and not by statements unsupported by adequate experimental evidence. Furthermore, since the negative attitude is based on preconceived arguments, none of which would have been modified by the results of the study, I wonder why the study was undertaken and published.

Yours faithfully,

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Book Reviews

Tropical Venereology. By O P Arya, A O Osoba, and F J Bennett. 1980. Pp 234. Churchill Livingstone, London and Edinburgh. Price £8.00.

Most books on venereology, or sexually transmitted diseases, have been written by authors whose main experience has been obtained at teaching centres in developed countries. While clinical descriptions are usually excellent, the value of sophisticated laboratory techniques for diagnosis may be emphasised. The practitioner in a tropical country, particularly outside the main centres of medicine, may find such techniques have little relevance to his practice. This book aims to fill the gap left by these previous accounts. It is a formidable task but has been ably undertaken by an eminent trio with clinical, epidemiological, and microbiological experience gained in Africa and in Britain. The usual pathological and clinical descriptions are given and the best diagnostic techniques are described. The differential diagnoses are particularly informative showing the need to consider a wider range of conditions in the tropics. Treatments follow standard patterns but there is emphasis on economical prescribing, a practice which can be applied with advantage all over the world. In addition there are appendices on the management of common conditions in situations where facilities are limited; this advice is practical and sensible in many tropical areas where budgets are limited.

Yet another name is introduced for what is widely called non-specific genital infection—namely, non-specific genital inflammatory disease—and some may grumble at the use of an even clumsier term which does nothing to clear an already complex topic. The subject is carefully covered in 19 pages. It is a reflection of the relative importance of such conditions as candidosis in the tropics that the condition is covered in three pages. I had also anticipated more in the chapter on genital manifestations of some tropical diseases. Furthermore, lymphogranuloma venereum can present as a more dramatic systemic illness, in the Far East at least, than is indicated by the description given.

There are useful accounts on the control of sexually transmitted diseases in the tropics, including advice on setting up a clinical service and appropriate laboratory facilities. There is a valuable section on health education and a more sophisticated account of epidemiological techniques in control. There is also a practical account on training auxiliaries who are responsible for primary health care in many rural tropical areas, where much of the population still lives.

One drawback must be mentioned and that concerns the clinical photographs. There are many black-and-white illustrations but their reproduction is of poor quality—presumably to reduce costs and so help make the book available to more readers. Despite this, I can recommend this book, for it succeeds admirably in its aim. It will be most useful to those working in the tropics. It should be read widely elsewhere for, as has been said before, sexually transmitted diseases travel the world at great speeds borne by air travellers.

R N Thin